The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhnas.com or call 1-877-356-0666. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.myhnas.com or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $1,000/person and $2,000/family. For out-of-network providers $3,000/person and $9,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $4,000/person and $8,000/family. For out-of-network providers $7,500/person and $22,500/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit. Deductible does not apply.	40% coinsurance*	None
	Specialist visit	$15/visit. Deductible does not apply.	40% coinsurance*	None
	Teladoc consultation	$5 copay. Deductible does not apply.	Not covered	None
	Chiropractic visit	10% coinsurance* after $15/visit	Not covered	Limited to 20 visits/year.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% coinsurance*	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance*	40% coinsurance*	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	40% coinsurance*	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance*	40% coinsurance*	None
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room care – emergent use	10% coinsurance after $75/visit. Deductible does not apply.	10% coinsurance after $75/visit. Deductible does not apply.	Copay waived if admitted.
	Emergency room care – non-emergent use	40% coinsurance*	40% coinsurance*	None
	Emergency medical transportation	10% coinsurance*	10% coinsurance*	None
	Urgent care	$15/visit. Deductible does not apply.	40% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance* after $100/admit	40% coinsurance*	Precertification required.**
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit. Deductible does not apply.	40% coinsurance*	Certain behavioral health services are not covered.
	Inpatient services	10% coinsurance* after $100/admit	40% coinsurance*	Precertification required.** Certain behavioral health services are not covered.
If you are pregnant	Office visits	No charge. Deductible does not apply.	40% coinsurance*	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	10% coinsurance*	40% coinsurance*	None
	Childbirth/delivery facility services	10% coinsurance* after $100/admit	40% coinsurance*	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	40% coinsurance*	Precertification required for out-of-network services.** Limited to 100 visits/year.
	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	10% coinsurance* after $15/visit	40% coinsurance*	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance*	40% coinsurance*	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	Durable medical equipment	10% coinsurance*	40% coinsurance*	Precertification required on select items.**
	Hospice services	10% coinsurance*	40% coinsurance*	Precertification required for inpatient care.** Limited to 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* Deductible applies.

** Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usscript.com	Individual maximum out-of-pocket amount	$2,000		The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
	Family maximum out-of-pocket amount	$4,000		
	Generic drugs	$15/prescription	$30/prescription	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the physician specifies "Dispense as Written".
	Preferred brand drugs	$25/prescription	$50/prescription	
	Non-preferred brand drugs	$40/prescription	$80/prescription	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-356-0666.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1000**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$140
Coinsurance	$1050
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2250**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1000**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$1310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1000**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$810
Copayments	$110
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$990**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $500/person and $1,000/family. For out-of-network providers $1,500/person and $4,500/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $3,500/person and $7,000/family. For out-of-network providers $6,000/person and $18,000 /family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit. Deductible does not apply.	40% coinsurance*	None
	Specialist visit	$15/visit. Deductible does not apply.	40% coinsurance*	None
	Teladoc consultation	$5 copay. Deductible does not apply.	Not covered	None
	Chiropractic visit	10% coinsurance* after $15/visit	Not covered	Limited to 20 visits/year.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% coinsurance*	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance*	40% coinsurance*	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	40% coinsurance*	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance*	40% coinsurance*	None
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room care – emergent use	10% coinsurance after $75/visit. Deductible does not apply.	10% coinsurance after $75/visit. Deductible does not apply.	Copay waived if admitted.
	Emergency room care – non-emergent use	40% coinsurance*	40% coinsurance*	None
	Emergency medical transportation	10% coinsurance*	10% coinsurance*	None
	Urgent care	$15/visit. Deductible does not apply.	40% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance* after $100/admit	40% coinsurance*	Precertification required.**
	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit. Deductible does not apply.	40% coinsurance*	Certain behavioral health services are not covered.
	Inpatient services	10% coinsurance* after $100/admit	40% coinsurance*	Precertification required.** Certain behavioral health services are not covered.
If you are pregnant	Office visits	No charge. Deductible does not apply.	40% coinsurance*	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	10% coinsurance*	40% coinsurance*	None
	Childbirth/delivery facility services	10% coinsurance* after $100/admit	40% coinsurance*	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	40% coinsurance*	Precertification required for out-of-network services.** Limited to 100 visits/year.
	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	10% coinsurance* after $15/visit	40% coinsurance*	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance*	40% coinsurance*	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	Durable medical equipment	10% coinsurance*	40% coinsurance*	Precertification required on select items.**
	Hospice services	10% coinsurance*	40% coinsurance*	Precertification required for inpatient care.** Limited to 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* Deductible applies.

** Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usscript.com	Individual maximum out-of-pocket amount	$2,000		The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
	Family maximum out-of-pocket amount	$4,000		
	Generic drugs	$10/prescription	$20/prescription	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the *physician* specifies "Dispense as Written".
	Preferred brand drugs	$25/prescription	$50/prescription	
	Non-preferred brand drugs	$40/prescription	$80/prescription	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$130
Coinsurance	$1100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1790**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$1100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1290**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$150
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$740**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhnas.com or call 1-877-356-0666. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.myhnas.com or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $0/person and $0/family. For out-of-network providers $200/person and $600/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers $3,000/person and $6,000/family. For out-of-network providers $4,700/person and $14,100 /family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	30% coinsurance*	None
	Specialist visit	$15/visit	30% coinsurance*	None
	Teladoc consultation	$5 copay	Not covered	None
	Chiropractic visit	15% coinsurance after $15/visit	Not covered	Limited to 20 visits/year.
	Preventive care/screening/ immunization	No charge	30% coinsurance*	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance*	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance*	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance*	None
	Physician/surgeon fees	15% coinsurance	30% coinsurance*	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room care – emergent use	15% coinsurance after $75/visit	Paid as in-network	Copay waived if admitted.
	Emergency room care – non-emergent use	30% coinsurance	30% coinsurance*	None
	Emergency medical transportation	15% coinsurance	Paid as in-network	None
	Urgent care	$15/visit	30% coinsurance*	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after $100/admit	30% coinsurance*	Precertification required.**
	Physician/surgeon fees	15% coinsurance	30% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit	30% coinsurance*	Certain behavioral health services are not covered.
	Inpatient services	15% coinsurance after $100/admit	30% coinsurance*	Precertification required.** Certain behavioral health services are not covered.
If you are pregnant	Office visits	No charge	30% coinsurance*	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance*	None
	Childbirth/delivery facility services	15% coinsurance after $100/admit	30% coinsurance*	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance*	Precertification required for out-of-network services.** Limited to 100 visits/year.
	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	15% coinsurance after $15/visit	30% coinsurance*	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	15% coinsurance	30% coinsurance*	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	Durable medical equipment	15% coinsurance	30% coinsurance*	Precertification required on select items.**
	Hospice services	15% coinsurance	30% coinsurance*	Precertification required for inpatient care.** Limited to 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* Deductible applies.

** Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.usscript.com	Individual maximum out-of-pocket amount	$2,000		The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
	Family maximum out-of-pocket amount	$4,000		
	Generic drugs	$10/prescription	$20/prescription	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the *physician* specifies "Dispense as Written".
	Preferred brand drugs	$15/prescription	$30/prescription	
	Non-preferred brand drugs	$30/prescription	$60/prescription	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$130
Coinsurance	$1720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1910**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$970
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$370**

The plan would be responsible for the other costs of these EXAMPLE covered services.